Clinical Guidelines for Termination of Pregnancy

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Valuable input was provided by the Northern Territory Termination of Pregnancy Law Reform Governance Advisory Group and the Northern Territory Termination of Pregnancy Clinical Guidelines Review Committee. Thanks go to all members for their ongoing work in informing these Guidelines.

All queries regarding these Guidelines can be:

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   OR

ii) addressed to:

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Introduction

Prior to 2017, abortion remained an offence in the Northern Territory under the Criminal Code Act 1983 (NT), other than when undertaken in accordance with section 11 of the Medical Services Act 1982 (NT).

The Termination of Pregnancy Law Reform Act 2017 (NT) was passed in March 2017 and enacted in July 2017. This legislation repealed and replaced section 11 of the Medical Services Act 1982 as well as parts of the Criminal Code Act 1983 (NT) which referred to the offences of procurement of an abortion or the supply of drugs or instruments for the procuring of an abortion.

The Termination of Pregnancy Law Reform Act 2017 (the Act) places the responsibility on medical practitioners assisted by registered health professionals to make termination of pregnancy decisions with a woman about her clinical care, having regard to the professional standards and guidelines. A termination of pregnancy performed by a suitably qualified medical practitioner (or a health practitioner assisting in the performance of the termination) will not result in a criminal offence for the woman, the medical practitioner or the health practitioner.

These Guidelines outline the changes the Act makes to the provision of termination of pregnancy in the Northern Territory and their implications for medical and health practitioners.

Scope

As the senior medical officer in the Northern Territory, the Chief Health Officer has set and published these Northern Territory Clinical Guidelines for Termination of Pregnancy (the Guidelines) in accordance with the Termination of Pregnancy Law Reform Regulations 2017.

The Guidelines are to be read in conjunction with the termination of pregnancy legislation and regulations.

The purpose of the Guidelines is to provide guidance and support in a Northern Territory context for all medical and health practitioners, including allied health and support services, participating in any aspect of the performance of a termination of a woman’s pregnancy or termination of pregnancy services.

The Guidelines do not provide advice on second trimester termination of pregnancy. The Chief Health Officer may set guidelines regarding second trimester termination of pregnancy at a later date.
The Guidelines are written in three sections.

Section 1 explains the governance structures for termination of pregnancy services.

Section 2 outlines clinical service delivery considerations for termination of pregnancy services.

Section 3 comprises six appendices which offer recommended practice points in the provision of termination of pregnancy services.

The first version of the Guidelines was published on 1 July 2017. This is the second version, published following a review in 2018.

Further reviews will occur following any substantial changes to medical treatment and/or legislative changes.
Section 1:
Governance
1.1 Governance structure

The following structure has been established for the safe and accessible provision of termination of pregnancy in the Northern Territory:

- Legislation: Termination of Pregnancy Law Reform Act 2017
- Regulations: Termination of Pregnancy Law Reform Regulations 2017
- Standards set by the Chief Health Officer (not set at this time)
- Guidelines: Northern Territory Clinical Guidelines for Termination of Pregnancy (these Guidelines)
- Professional Standards (set by medical colleges and regulatory authorities or bodies)

Figure 1. Governance Structure for Termination of Pregnancy in the NT
1.2 Legislation

Summary of previous legislation: Medical Services Act 1982

Prior to 2017, termination of pregnancy in the Northern Territory was prescribed by section 11 of the Medical Services Act 1982. This meant that a termination of pregnancy under 14+0 weeks gestation could only be performed in a hospital. In addition, there was a requirement that two medical practitioners must examine the woman and that at least one of these medical practitioners was a gynaecologist or obstetrician.

Terminations of pregnancy that were undertaken after 14+0 weeks gestation but not more than 23+0 weeks gestation required a single medical practitioner. The medical practitioner was not required to specialise in obstetrics or gynaecology. The risks in these cases might be higher than for termination of pregnancy for women at earlier gestations. Finally, there were previously no provisions regarding conscientious objection or safe access zones.

The Termination of Pregnancy Law Reform Act 2017 repeals and replaces section 11 of the Medical Services Act 1982 and sets the criteria for the provision of safe termination of pregnancy services in the Northern Territory.

Summary of new legislation: Termination of Pregnancy Law Reform Act 2017

The following is a summary of key elements of the Act:

• A suitably qualified medical practitioner may perform a termination of pregnancy by performing a surgical procedure; by prescribing, supplying or administering a termination drug or drugs; or by any other action.

• A single suitably qualified medical practitioner may perform a termination of pregnancy on a woman who is not more than 14+0 weeks pregnant if that medical practitioner considers the termination is appropriate in all circumstances having regard to all medical circumstances and the woman’s current and future physical, psychological and social circumstances.

• A suitably qualified medical practitioner may perform a termination of pregnancy on a woman who is more than 14+0 weeks but not more than 23+0 weeks pregnant if that medical practitioner has consulted with at least one other suitably qualified medical practitioner who has assessed the woman, and each considers the termination is appropriate in all circumstances having regard to all medical circumstances and the woman’s current and future physical, psychological and social circumstances.

• A suitably qualified medical practitioner can direct an authorised Aboriginal Health Practitioner, authorised midwife, authorised nurse or authorised pharmacist to assist in the performance of a termination of pregnancy.
• The suitably qualified medical practitioner needs to have regard to the professional standards and guidelines, including these Guidelines, in the assessment and management of the woman seeking termination of pregnancy services. The definition of professional standards and guidelines is set out in the Act, and those to which the suitably qualified medical practitioner needs to have regard are listed in these Guidelines. (See section 1.5).

• The Act does not stipulate the care settings in which a woman may have a termination of pregnancy. This decision is left to the suitably qualified medical practitioner in consultation with the woman, after assessment of the woman and her risks and circumstances, with regard to the professional standards and guidelines.

• The Act requires those who hold a conscientious objection to inform the woman of this and refer her to another medical practitioner who does not have a conscientious objection. It is important such a referral be timely, for example within a maximum of two days following initial consultation.

• The Act establishes safe access zones in the vicinity of premises performing terminations.
1.3 Regulations

The *Termination of Pregnancy Law Reform Regulations 2017* (the regulations) state directives and set penalties under the *Termination of Pregnancy Law Reform Act 2017*. The regulations apply to public, non-government and private providers of termination of pregnancy services. The following regulations have been made under the Act:

- The setting and verification of credentials by the Chief Health Officer
- The setting of standards and guidelines in relation to the performance of a termination of pregnancy or the provision of termination of pregnancy services by the Chief Health Officer
- The provision of prescribed information by medical practitioners to the Chief Health Officer
- Confidentiality of information relating to the termination of a woman’s pregnancy
- Applicable penalties.

**NOTE:** The following pages (sections 1.4 to 1.7) provide information on the practical application of the regulations
1.4 Setting credentials

The *National Standard for Credentialing and Defining the Scope of Clinical Practice 2004* published by the Australian Council for Safety and Quality in Health Care is the standard to be applied for the setting of credentials.

Other than in an emergency, a medical practitioner must be credentialed as being ‘suitably qualified’ in order to perform a termination of pregnancy.

The definition of ‘suitably qualified medical practitioner’ in the Act requires the medical practitioner to be:

(a) an obstetrician or gynaecologist; or

(b) credentialed in the provision of advice, performance of procedures and giving treatment in the area of fertility control.

The Chief Health Officer has set the following credentials as being those required for recognition as a 'suitably qualified medical practitioner'. A medical practitioner must be able to satisfy the Chief Health Officer (or a delegate of the Chief Health Officer) that they meet one or more of the following criteria:

- Australian Health Practitioner Regulation Agency (AHPRA) registration as a specialist obstetrician or gynaecologist
- an award of the Diploma Royal Australian New Zealand College of Obstetricians and Gynaecologists (DRANZCOG) Advanced qualification from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- AHPRA registration as a medical practitioner who is currently certified under the Therapeutic Goods Administration licensing conditions to prescribe MS-2Step
- AHPRA registration as a medical practitioner who also has sufficient experience in the surgical performance of termination of pregnancy to be deemed, by an independent practising gynaecologist, as being competent to perform surgical termination procedures independently and safely.

A registrar in obstetrics and gynaecology or general practice may act as a suitably qualified medical practitioner, if acting under the supervision of a suitably qualified medical practitioner. A registrar’s ability to prescribe MS-2Step in such circumstances depends on their certification under the Therapeutic Goods Administration (TGA) licensing conditions.

A suitably qualified medical practitioner’s scope of practice depends on their credentials. A suitably qualified medical practitioner whose credentials are restricted to TGA
prescriber certification only cannot undertake surgical termination procedures. A suitably qualified medical practitioner whose credentials are restricted to surgical procedures only cannot undertake medical terminations of pregnancy.

1.4.1 Verification of credentials

The Chief Health Officer is responsible for verifying the credentials of suitably qualified medical practitioners. Under the provisions of the Public and Environmental Health Act 2011 (NT), the Chief Health Officer is able to delegate a function of the Chief Health Officer to specified person(s).

The Chief Health Officer has, by instrument, delegated the function of verifying the credentials of suitably qualified medical practitioners to the executive officer, senior clinician or manager of a number of Northern Territory based health practices or facilities providing termination of pregnancy services.

The Chief Health Officer is to perform this function for a sole practitioner or for a practitioner whose executive officer, senior clinician or manager does not wish to be a delegate for credentialing procedures.

Other practitioners, practices or facilities providing termination of pregnancy services may also seek a delegation of the Chief Health Officer to permit them to verify the credentials of medical practitioners who will be performing termination of pregnancy services.

A delegate of the Chief Health Officer must maintain appropriate records of the verification process. This includes keeping copies of credential verification documents, as these will be requested by the Chief Health Officer.

The delegate (or the Chief Health Officer) is required to review the credentials of a suitably qualified medical practitioner at intervals of no more than two years. The medical practitioner must meet the minimum credentials at the time of review to maintain recognition as a suitably qualified medical practitioner.

The Chief Health Officer has the power to request access to records of a delegate to undertake a review of the verification of credentials of a medical practitioner to be recognised as a suitably qualified medical practitioner.
1.4.2 Penalties

Medical practitioners must provide true and accurate information to the Chief Health Officer for their credentialing. Intentionally providing false or misleading credentialing information to the Chief Health Officer may result in a penalty.

A penalty will not apply under two circumstances:
1. the medical practitioner draws the misleading aspect to the Chief Health Officer when providing the credentialing document; or
2. the medical practitioner provides the Chief Health Officer with the information necessary to remedy the misleading aspect of the document.

1.4.3 Credential verification form

The Chief Health Officer has prepared a form for use by the delegates which meets the requirements for appropriate records of credentialing of a suitably qualified medical practitioner. The form is designed to assist with the process of credentialing and associated record keeping or review.

It is not mandatory to use the form, but it may be a quick and simple means of ensuring the process is appropriately undertaken and ensuring a suitable record is available for the practice and for the medical practitioner if there was ever any question about the lawfulness of a termination performed.

When completed the forms are retained by the delegate but must be available for sighting as requested by the Chief Health Officer.

This form can be downloaded from the Department of Health website.
1.5 Setting standards and guidelines under the regulations

The Chief Health Officer has the ability to set standards and guidelines in relation to termination of pregnancy. The Chief Health Officer has not yet set any standards. However, the Chief Health Officer has issued these Guidelines.

While the Chief Health Officer has chosen not to set standards, all practitioners performing terminations must have regard to applicable professional standards, guidelines and statements.

1.5.1 Professional Standards

Professional standards and guidelines which have informed these Guidelines, and to which medical and health practitioners are required to have regard are:

- Royal Australian and New Zealand College of Obstetricians and Gynaecologists College Statement C-Gyn 17, Termination of pregnancy
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists College Statement C-Gyn 21, The use of mifepristone for medical termination of pregnancy
- MS Health Certificate prescriber information
- Product information, MS-2Step Version 24 December 2014 [63 days]
- Consumer product information, MS-2Step GyMiso ©Misoprostol 200 mcg tablets
- Royal College of Obstetricians and Gynaecologists, Evidence-based Clinical Guidelines Number 7; The Care of Women Requesting Induced Abortion: Summary 2011.

Organisations and service providers providing termination of pregnancy services may wish to develop their own protocols specific to their needs and locations.

1.5.2 Penalties

Penalties do not apply under the regulations if a medical practitioner does not have regard to professional standards or guidelines. However, non-compliance may result in disciplinary proceedings should a complaint be raised.
1.6 Provision of prescribed information

Suitably qualified medical practitioners must provide the Chief Health Officer with prescribed information regarding termination of pregnancy within a prescribed timeframe. These reporting requirements are set out in Part 4 of the regulations.

The prescribed information is:

• date of birth of the woman
• gestational age
• the date the termination was initiated or performed
• the method of termination
• region of woman's usual residence (based on local government areas)
• full name and provider number of the suitably qualified medical practitioner performing the termination
• full name and provider number of the second suitably qualified medical practitioner consulted for post 14 week termination of pregnancy
• the location where the termination was initiated (for early medical terminations) or performed (for surgical terminations including terminations post 14-weeks)
• the name of the facility (where relevant)
• that a follow-up appointment was made.

1.6.1 Reporting timeframes

For surgical terminations, reporting must be completed within 28 days of performance of the termination.

For early medical terminations, reporting must be completed within 28 days of the medical practitioner’s last consultation with the woman. This may be the consultation at which the medical practitioner prescribed the drugs, or at a later consultation, for example a follow-up appointment after the termination was performed. If a woman does not return for a follow-up appointment, the timeframe for measuring 'the last consultation with the woman is 28 days from the consultation during which the drugs were prescribed. It is therefore necessary to carefully monitor the time frame for reporting to the Chief Health Officer.

For any other termination (for example a combination of medical and surgical), reporting must be completed within 28 days of performance of the termination.
1.6.2 Approved prescribed information reporting form

The Chief Health Officer has approved a prescribed information reporting form. This form can be downloaded from the Department of Health website.

All completed forms must be sent to:

Strategy Policy and Planning Branch
PO Box 40596 Casuarina NT 0811
Email: WomensHealth.DoH@nt.gov.au

1.6.3 What happens to the prescribed information?

The information will be managed according to the same strict confidentiality requirements that apply to all other information collected for health-related purposes, such as information collected, stored and used for the Northern Territory perinatal register and cancer register. The information collected does not include any personal information identifying the woman concerned.

The Chief Health Officer will provide reports to the Chief Executive of NT Health relating to terminations of pregnancy and related services. Such a report will not contain identifying information relating to any person. This will assist the Department of Health to assess whether the Act is achieving its objects, including whether access to termination of pregnancy services has been improved and whether medical and health practitioners are adequately regulated.

1.6.4 Penalties

Failure to provide prescribed information within the prescribed time may attract a penalty. A penalty will not be incurred if a reasonable explanation can be provided.
1.7 Disclosure of confidential information

Part 4 of the regulations describes the penalties for failing to maintain the confidentiality of information regarding a woman and the provision of a termination of pregnancy service.

1.7.1 Penalties
A penalty may apply if:

i. a person obtains confidential information by:
   • acting or assisting in any way in connection with the performance of a termination; or
   • being present at a place where a confidential matter is evident or being discussed; or
   • administering the Act and these regulations (e.g. mishandling reporting forms).

ii. and the person intentionally discloses the confidential information and is reckless in relation to the result of this disclosure.
Section 2:
Clinical Service Delivery
Figure 2. Termination of pregnancy service pathway summary

**UNPLANNED PREGNANCY OR SUSPECTED FETAL ABNORMALITY**

-> PROVIDE PREGNANCY OPTIONS INFORMATION

**REQUEST**

-> TERMINATION

**CONSCIENTIOUS OBJECTOR**

- Discloses
- Refers to doctor / medical facilities with NO conscientious objection within two days

**Perform DATED ultrasound**
- confirm gestational age
- intrauterine pregnancy

**Routine tests**
- FBE blood group
- antibodies
- STI swabs

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**LESS THAN 14 WEEKS**

Assessment by 1 suitably qualified medical practitioner

**MEDICAL COMORBIDITIES/CONTRAINDICATION**

Discuss with Obstetrician/Gynaecologist as required

**NO MORE THAN 9 WEEKS**

Medical TOP using TGA approved MS2-Step protocol
- Follow Practice Points Appendix C

**NO MORE THAN 14 WEEKS**

Surgical TOP
- Follow Practice Points Appendix D

**RISK MANAGEMENT**

Stay within 2 hours drive from a hospital for the entire procedure
- See GP or local clinic 14-21 days post termination

**RISK MANAGEMENT**

Stay within 2 hours drive from a hospital for 24 hours after procedure
- See GP or local clinic 14-21 days post termination

**FOLLOW UP APPOINTMENT**

Confirmation of Termination of Pregnancy. See Appendix E

**CONTRACEPTION PROVIDED**

**Complete Reporting**

Complete Prescribed Information Reporting Form
www.health.nt.gov.au

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**AT ALL POINTS** in service delivery consider:

i. CONSENT (must be written)
ii. COUNSELLING
iii. INTERPRETER
iv. MANDATORY REPORTING
2.1 Unplanned pregnancy or suspected fetal abnormality

Many women are faced with an unplanned or unexpected pregnancy at some time in their life. While there are no confirmed numbers, it is estimated there are around 200,000 unplanned pregnancies every year in Australia.

Some women may have a planned pregnancy but find out there is a problem with the pregnancy or an abnormality has been found or is suspected.

Pregnancy options information focuses on a woman's unplanned pregnancy or pregnancy concerns and supports her to make decisions. Such information must be unbiased and non-judgmental. A woman should be made aware that impartial, non-judgmental pregnancy options information is available should she wish to access this.

Not all women experiencing an unplanned pregnancy need or want additional information or counselling and provision of these services is not mandatory. Some women will however seek support to make a decision about the pregnancy, which could include online decision making tools, discussion with family and friends and/or professional support and counselling.

Pregnancy options counselling may be beneficial for women when considering suspected or confirmed fetal abnormality. Counselling may also benefit women with specific vulnerabilities such as young women, those who are pregnant as a result of rape or sexual abuse or, who are unable to make informed decisions.

The woman’s choice to continue a pregnancy or to terminate the pregnancy, should be supported.

A ‘Pregnancy options for women in the Northern Territory’ booklet can be downloaded from the Department of Health website.
2.2 Conscientious objection

Medical and health practitioners who have a conscientious objection to termination of pregnancy may decline to provide termination of pregnancy services. However, the Act requires a medical or health practitioner who has a conscientious objection to inform the woman of this.

The medical or health practitioner must then refer the woman in a timely manner, for example within two working days, to another medical practitioner who does not have a conscientious objection or to a facility known to provide terminations of pregnancy and must provide the woman with relevant contact details.

The Act also allows a suitably qualified medical practitioner to direct an authorised health practitioner to assist in the performance of a termination of pregnancy. If a health practitioner has a conscientious objection to assisting with the provision of termination services, the health practitioner must inform the medical practitioner of this, and it will be the responsibility of the suitably qualified medical practitioner to direct another authorised health practitioner who does not have a conscientious objection in relation to the provision of termination services, to assist with the provision of the services as required.

This process should be undertaken in consultation with the woman to ensure the relevant information is given to her and the services are provided as soon as possible.

A suggested referral form for conscientious objectors (called ‘Referral for Pregnancy Services’) can be downloaded from the Department of Health website.
2.3 Request for termination of pregnancy services

Suitably qualified medical practitioners providing termination services should consider all relevant clinical and psychosocial matters including pre-existing mental health issues, social circumstances and availability of formal and informal support services for a woman seeking termination.

A pre-termination assessment is important to ensure that the woman understands:

- the nature of her clinical condition
- the nature and purpose of the proposed treatment
- the effects of the treatment including side effects
- the consequences of non-treatment
- all treatment options
- possible repercussions of the proposed treatment.

A ‘Having a termination of pregnancy in the Northern Territory’ booklet can be downloaded from the Department of Health website.

2.3.1 Authorised health practitioners

The suitably qualified medical practitioner may be assisted by an authorised health practitioner in the performance of a medical termination on a woman who is no more than 14 weeks pregnant. This will only occur if the suitably qualified medical practitioner considers the termination appropriate. The word ‘authorised’ refers to the application of the Medicines, Poisons and Therapeutic Goods Act 2017 (NT) to the role of a nurse, midwife, pharmacist, or Aboriginal and Torres Strait Islander health practitioner in the supply and administration of medication.

2.3.2 The role of the authorised pharmacist

A pharmacist must be certified in accordance with TGA licensing conditions through MS Health before ordering termination of pregnancy medication (MS-2 Step).

A pharmacist must confirm that the prescribing doctor is a certified prescriber before dispensing a prescription for MS-2 Step.

The pharmacist must provide adequate pharmaceutical information to the woman and/or her support person to ensure the safe and effective use of the drugs in a manner that protects the woman’s privacy.
2.4 Counselling

Not all women experiencing an unplanned pregnancy need or want counselling and it is not mandatory. Some women will, however, seek support to make a decision about the pregnancy, which could include family, friends and/or professional support and counselling.

Culturally sensitive counselling should be offered in as close proximity as possible to where the woman is residing to promote continuity and availability of longer term counselling should she want this.

2.4.1 Vulnerable women

Where a young woman is 16 years of age or under, greater consideration of an independent and appropriate counsellor/support person being available and engaged should be considered. This is irrespective of whether the young woman is deemed Gillick competent or not Gillick competent or whether parents, guardians or a Court can provide consent. (Refer to 2.6.2)

A young woman sixteen years of age or under can be vulnerable and may need additional support and information to fully understand their options in regard to an unplanned pregnancy.

The suitably qualified medical practitioner should identify in their practice and community context appropriate persons to take on the role of independent counsellor/support person for particularly vulnerable women including young women. This may include the provision of a local community support person, contacting organisations which can provide an appropriate person, or consultation with social workers at the local hospital.

In circumstances where a counsellor/support person is not available in person, consideration should be given to arrange their attendance using tele-conference or tele-health links.

Any involvement of the counsellor/support person must be documented in the woman’s medical records by the suitably qualified medical practitioner.

For more information about psychological support and counselling see Appendix A.
2.5 Mandatory reporting

All adults within the Northern Territory are required to report cases of child abuse and neglect as well as concerns of possible serious injury or threat to life from domestic and family violence to the relevant agencies. Failure to meet this legal obligation is an offence and can result in significant penalties being imposed. In addition to the legal obligation, NT Health clinicians have a professional responsibility to ensure a mandatory report is made when required.

2.5.1 Forensic investigation

If a woman or girl requesting a termination of pregnancy presents within seven days of experiencing sexual violence, she should be referred (with consent) to NT Health's Sexual Assault Referral Centre (SARC) following the local sexual assault procedure. A medical or health practitioner may be required to undertake the following:

- if the woman is under the age of 18 years, follow mandatory reporting procedures (see below)
- take a history and conduct the forensic examination
- treat any physical injuries
- the woman or girl (if she has not already) is not to wash and her clothes are to be removed and placed in a paper (not plastic) bag for forensic investigation.

2.5.2 Mandatory Reporting - child abuse and neglect

*Care and Protection of Children Act 2007 (NT)*

Section 26(1) and (2) of the Care and Protection of Children Act 2007 states that it is an offence if any adult in the Northern Territory does not report to Territory Families if they have formed a belief that a child has been, or is at risk of harm or exploitation. This also applies in cases where a child has been or is likely to be the victim of a sexual offence. A person is guilty of an offence if the person believes any of the following:

- a child has suffered or is likely to suffer harm or exploitation; or
- a child aged 14 to 16 years is sexually active and the age difference between the child and the alleged sexual offender is more than two years; or
- a child aged less than 14 years has been or is likely to be a victim of a sexual offence; or
- a child has been or is likely to be a victim of an offence against section 128 of the Criminal Code Act 1983;
and does not, as soon as possible after forming that belief, report (orally or in writing) to Territory Families:

- that belief; and
- any knowledge of the person forming the grounds for that belief; and
- any factual circumstances on which that knowledge is based.

Definitions under the Care and Protection of Children Act 2007 include psychological and/or physical harm.

In this legislation witnessing violence between family members at home is specifically provided as an example of the potential harm to the child.

Reports can be made 24 hours a day every day of the year to the Territory Families Central Intake Team on 1800 700 250. However, should you believe that a child’s safety is at immediate risk a report can be made directly to the NT Police on 000 (emergency) or 131 444, followed by a notification to Territory Families.

### 2.5.3 Mandatory Reporting – domestic and family violence

**Domestic and Family Violence Act 2007 (NT)**

Section 124A of the Domestic and Family Violence Act 2007 requires every adult in the Northern Territory to make a report to Police if they believe on reasonable grounds either or both of the following:

- a person has caused or is likely to cause serious physical harm to someone with whom the person is in a domestic relationship;
- the life or safety of a person is under serious or imminent threat because domestic violence has been, is being or is about to be committed.

Section 125(1) of the Domestic and Family Violence Act 2007 states that:

- a person acting in good faith in making a report is not civilly or criminally liable or in breach of any professional code of conduct for making the report or for disclosing any information in the report.
- a mandatory report is required when the level of harm, as described in the Criminal Code Act 1983 has been met. Section 1A of the Criminal Code Act 1983 describes harm as; physical harm or harm to a person's mental health, whether temporary or permanent and includes unconsciousness, pain, disfigurement, infection with disease and any physical contact with a person that a person
might reasonably object to in the circumstances, whether or not the person was aware of it at the time.

Mandatory reporting of domestic and family violence is made to **NT Police 000 (emergency) or 131 444**.

All adults in the Northern Territory are required to notify Territory Families if a child is a victim or otherwise present during a domestic and family violence incident. Reports can be made 24 hours a day every day of the year to the **Territory Families Central Intake Team on 1800 700 250**.
2.6 Consent

Where a woman is seeking to terminate a pregnancy, it is necessary to obtain written informed consent to the type of procedure recommended by the suitably qualified medical practitioner and selected by the woman.

To achieve this requires provision of suitable levels of information. The woman needs to be able to weigh up all the factors relevant to her and the risks involved. If more than one step or procedure is involved then it is important to ensure the woman is giving consent to each step or procedure.

The suitably qualified medical practitioner performing the termination is required to discuss the material risks associated with either a surgical or medical termination (those risks to which the woman is reasonably likely to attach significance).

In all cases the woman is to be informed that surgical and medical methods of termination carry a small risk of failing to end the pregnancy. This is a significant reason for ensuring the woman attends a follow up examination at the scheduled time and place.

The suitably qualified medical practitioner will need to be satisfied that all relevant information was given and that the woman demonstrated an understanding of the procedures involved, the effect of the procedures and the associated risks.

2.6.1 Capacity to consent

Persons over the age of 18 years are presumed to have full lawful capacity to consent to medical treatment unless there is sufficient evidence to the contrary (see s5(2) of the Guardianship of Adults Act 2016 (NT)).

Capacity to consent is usually evidenced by the person’s demonstration of a sufficient understanding of the condition, the treatment options available (including the benefits and effects of treatment options), the consequences of the condition and those of having or not having any treatment, and the risks associated with each treatment.

A woman over 18 years of age seeking a termination of pregnancy will be presumed to have capacity to provide consent to the termination service sought. Generally, women from the age of 16 years on will be considered mature enough and to have the relevant capacity to give consent to termination procedures.

However, there is no statutory provision supporting the legality of this. Only common law provisions apply to women under 18 years of age in the Northern Territory. This requires the suitably qualified medical practitioner to assess the capacity of a woman under the age of 18 years to provide consent.
If a suitably qualified medical practitioner considers there is some doubt about the capacity of a woman to understand the condition, treatment options, or associated risks, then further enquiries should be made to ensure the woman does have legal capacity to give consent. The following paragraphs may assist with the capacity issue.

### 2.6.2 A young woman with capacity; *Gillick* competence

A young woman under the age of 18 years may have capacity to make decisions for herself and to give consent to medical treatment (including termination of pregnancy). There are no statutory provisions in relation to the ability of persons under 18 years of age to give consent to medical treatment. However, the common law does consider young women may be capable of giving informed consent as their age increases and maturity develops.

The common law was developed through the English House of Lords in the case of *Gillick* and was approved by the Australian High Court in the case of *Marion*. The capacity of a young woman to consent to medical treatment is evidenced by “a sufficient understanding and intelligence to enable her to understand fully what is proposed”.

A woman over the age of 16 years might be considered to have capacity to give consent to medical treatment. However, the suitably qualified medical practitioner should not simply assume this is the case. The practitioner should make suitable enquiries of the woman's decision-making process to determine if she does have the maturity and understanding of her circumstances and the gravity of the decision.

A young woman under the age of 16 years may have capacity to give consent to medical treatment if it can be demonstrated that she meets the criteria of *Gillick* competence.

A suitably qualified medical practitioner will contemplate the following when considering whether a woman is *Gillick* competent:

- age
- psychiatric, psychological and emotional state
- understanding of the nature and consequences of pregnancy
- understanding of the nature and consequences of the proposed treatment, in relation to the short term and long term physical and emotional effects
- maturity, intellect and life experience
- the ability to understand the wider consequences of the decision which might include the effect on other people, and moral and family issues.

Mandatory reporting requirements for sexual offences apply irrespective of the
treatment sought. The suitably qualified medical practitioner must be aware of the legal obligations regarding mandatory reporting.

2.6.3 A young woman less than 14 years
A young woman under the age of 14 years should not be presumed to have capacity to give consent to medical treatment. In the majority of cases, a young woman under the age of 14 years would require a parent or person having parental authority to provide consent to treatment.

Mandatory reporting requirements for sexual offences and possible sexual abuse apply irrespective of the treatment sought. The suitably qualified medical practitioner should consider these requirements carefully.

2.6.4 Obtain written consent
Once the relevant level of information has been provided, the woman should be asked to provide her written consent for the procedure she has selected. Health and medical practitioners are encouraged to document that:

- the woman acknowledged and understood the information provided
- she made her own decision, having regard to the risks and nature of the consequences
- she consented to the procedure being performed.

2.6.5 An adult woman who lacks capacity
A woman over 18 years of age who lacks the capacity to provide informed consent to a procedure for termination of pregnancy will require assistance to consent to treatment.

- Under normal circumstances a guardian or next of kin cannot provide consent to a termination of pregnancy. The issue needs to be determined by the Northern Territory Civil Administrative Tribunal, Local Court or Supreme Court depending on the circumstances. The suitably qualified medical practitioner should seek legal advice.

- A woman’s valid Advanced Personal Plan should be followed. Legal advice will be required to ensure the validity of the Advanced Personal Plan.
• Under emergency circumstances the provisions of the *Emergency Medical Operations Act 1973* (NT) apply.

### 2.6.6 A young woman who lacks capacity

For a young woman under the age of 18 years who lacks capacity to make decisions about her day to day life or general medical treatment, it is necessary to consider seeking the consent of the young woman’s parent(s) or the Court before undertaking the proposed treatment. It is recommended that legal advice is sought if there is any doubt about the capacity of a young woman to consent to the proposed treatment and no other person is representing her or presenting orders permitting the proposed treatment.

Where another person is seeking the treatment on behalf of a young woman who apparently lacks capacity to give consent, the lawful basis upon which that person purports to represent the young woman must be verified before proceeding with any treatment. That is, the person will be asked to provide a copy of all relevant Court Orders appointing a guardian for the young woman and identification of the guardian, as well as documents identifying the parent and relationship to the young woman (e.g., Medicare card or other verification) documented in the young woman’s medical record.

It is also recommended that any legal documents be verified by a legal representative of the suitably qualified medical practitioner before proceeding with treatment. In some cases, the suitably qualified medical practitioner may need to become involved in the types of legal proceedings mentioned above, either by way of supporting one of the persons wishing to be appointed as a representative of the woman, or by seeking consent orders. In these cases, it is recommended that the suitably qualified medical practitioner seek legal advice and possibly representation at any hearing.
2.7 Domestic and family violence

The Northern Territory has the highest rates of domestic and family violence in Australia.

Domestic violence (also known as intimate partner violence) includes physical and sexual violence; threats and intimidation; emotional abuse and social isolation; stalking; and financial deprivation.

Domestic violence can involve a continuum of controlling and abusive behaviour and violence, which can occur over a number of years and continue after a relationship has ended.

Aboriginal communities have supported the use of the term 'family violence' to indicate the impact violence has on kinship and family ties and the broader community. However, family violence can also refer to violence across and within families such as child abuse and elder abuse. Such violence can also involve stressors that lead to self-harm and suicide.

While physical violence and its impacts can sometimes be more visible, emotional abuse (telling someone they are useless, a bad parent or mad), social isolation (preventing or restricting someone's contact with family and friends) and economic abuse (denying or restricting access to money) are not as obvious but can have devastating effects for the victim.

Ongoing domestic and family violence can result in the victim having difficulty recognising the abuse ('normalising' the abuse) and in turn struggling to take action for change. Notably, planning to leave or leaving an abusive relationship is a recognised risk for escalating violence and homicide.

Violence can affect same-sex partners and domestic and family relationships between people of all ages.

While men can be the victims of domestic and family violence, research shows that women and children are overwhelmingly the victims of this violence and men are the majority of perpetrators.

Pregnancy is a known risk period for women to either first experience domestic and family violence or for an escalation in such violence.

There is also emerging evidence that domestic and family violence includes previously under reported high levels of sexual abuse and assault and reproductive control.

2.7.1 Reproductive control and coercion
Reproductive control is defined as "behaviours that interfere with women's reproductive autonomy as well as any actions that pressurise or coerce a woman into initiating or terminating a pregnancy" (Rowlands and Walker, 2019). Such control comprises a wide range of behaviours, from persuasion to pressure and includes emotional blackmail, societal or family expectations and/or threats of or actual physical violence.

Reproductive coercion is a subset of reproductive control and is a form of domestic and family violence. Reproductive coercion can include birth control sabotage (where contraception is deliberately thrown away or tampered with); stealthing (where a condom is surreptitiously removed); threats and the use of physical violence if a woman insists on the use of contraception; emotional blackmail; coercing a woman to have sex, fall pregnant or have an abortion, as well as rape. Women can experience coercion from a partner to either become pregnant, progress with a pregnancy they do not want or terminate a pregnancy they wish to continue. Such behaviour usually occurs in the context of an already violent relationship.

2.7.2 Identifying and responding to domestic and family violence and reproductive control and coercion

There is no one agreed method of identifying or screening for domestic and family violence or reproductive control. However, there are a number of well evidenced tools and risk assessment forms that can be used as part of the termination of pregnancy pre-assessment process.

A suggested screening tool for domestic and family violence is available at Appendix F.

Any questions about or screening for domestic and family violence or reproductive coercion should only be asked of a woman or girl WHEN SHE IS ALONE. The presence of a partner, friend or family member could create significant risk and the screening must not proceed.

If a woman or girl discloses domestic, family or sexual violence the suitably qualified medical practitioner must be aware of mandatory reporting procedures (as per Section 2.5 of these Guidelines).

It is recommended that all suitably qualified medical practitioners make themselves familiar with the services offered and referral processes to local domestic and family violence and sexual violence service providers.
A list of domestic family and sexual violence service providers is available on the NT Health Termination of Pregnancy website for health professionals

Further information about reproductive coercion is available from the Queensland based organisation Children by Choice website
https://www.childrenbychoice.org.au/factsandfigures/reproductivecoercion

### 2.8 Culturally appropriate care and use of Interpreters

Women’s needs vary in termination care and the woman’s cultural background may or may not be similar to her health care provider. Providing female health care providers and female chaperones may assist women to access reproductive health services. In some cases professional interpreters are needed to fully explain and gain consent. If an interpreter is required, engage a professional interpreter and not a family member.

Women are to be provided with written information (see the *Pregnancy options for women in the Northern Territory* booklet) as well as verbal information in a language or way that they understand.

The Northern Territory Women’s Business Manual (Minymaku Kutju Tjurupa) is designed for practitioners working with Aboriginal women from rural and remote areas. It provides [helpful advice on assisting women with terminations of pregnancy](https://www.docs.nt.gov.au/interpreting/itsnt/make_a_booking/ITSNT_booking_request).

Having a diversity of health team members, which may include an Aboriginal and Torres Strait Islander Health Practitioner (ATSIHP) or Aboriginal Health Worker (AHW), can help in providing culturally appropriate care. If unsure - seek advice from a local Cultural Advisor who does not have a conscientious objection to termination of pregnancy.

**Interpreter Services contact details**


Interpreting and Translating Service NT 8999 8506 or 1800 676 254 (0830-1600) [www.docs.nt.gov.au/interpreting/itsnt/make_a_booking/ITSNT_booking_request](http://www.docs.nt.gov.au/interpreting/itsnt/make_a_booking/ITSNT_booking_request)

Aboriginal Interpreter Service 8999 8353 or ais@nt.gov.au or booking request [www.docs.nt.gov.au/_data/assets/pdf_file/0003/6492/AIS_booking_request.pdf](http://www.docs.nt.gov.au/_data/assets/pdf_file/0003/6492/AIS_booking_request.pdf)

Deaf Interpreter Service 8945 2016 or 0429 452 016 [www.deafnt.org.au](http://www.deafnt.org.au)
2.9 Pre-termination assessment and referral pathways

Recommended practice points have been set to assist service providers regarding pre-termination assessment and referral pathways. These practice points can be found at Appendix B.

2.10 Early medical termination: recommended practice points

Recommended practice points have been set to assist service providers performing early medical terminations of pregnancy up to 14 weeks gestation. A key safety consideration is the woman must, at all times during the early medical termination, be no more than a two hour drive from a hospital.

These practice points can be found at Appendix C.

2.11 Surgical termination of pregnancy up to 14 weeks: recommended practice points

Recommended practice points have been set to assist service providers performing surgical terminations of pregnancy up to 14 weeks gestation.

These practice points can be found at Appendix D.

2.12 Aftercare, complications and sequelae of termination of pregnancy: recommended practice points

Recommended practice points have been set to assist service providers with aftercare and complications of termination of pregnancy.

These practice points can be found at Appendix E.
2.13 Record keeping

The suitably qualified medical practitioner and health practitioners are required to keep accurate health care records concerning the care and treatment of the woman.

Documentation should include:

- an assessment of the pregnancy
- clinical opinion relevant to the woman’s medical circumstances and her current and future physical, psychological and social circumstances and the relevant professional standards followed
- a detailed and well documented informed decision making process
- clinical process to determine successful completion of termination
- details of follow up appointments
- location of the termination
- details of discussion of and provision of contraception.

2.14 Patient Assisted Travel Scheme (PATS)

When a woman requires an early medical termination of pregnancy and does not have access to safe accommodation within two hours driving time from a hospital, she will be eligible for financial assistance through PATS. Assistance provided will include transport and accommodation costs and automatic eligibility for an escort. The woman will be covered under the PATS program until she is discharged by a suitably qualified medical practitioner. Any further follow up appointments required for this procedure will also be covered by PATS.

2.15 Safe access zones

The Act provides for offences where a person intentionally and recklessly engages in prohibited conduct within a ‘safe access zone’. A safe access zone is defined as being the area within the premises performing termination of pregnancy services and extends to 150 metres from the boundary.

Prohibited conduct means harassing, hindering, intimidating, interfering with, threatening or obstructing a person, including by recording the person by any means without the person’s consent and without a reasonable excuse, which may deter the person from entering or leaving the facility, and/or performing or receiving a termination at the facility.
Prohibited conduct also includes an act that could be seen or heard by a person in the vicinity of a facility which performs terminations which may result in deterring a person entering or leaving the facility, and/or performing or receiving a termination.

A publication of a recording taken without a person’s consent within a safe access zone may also constitute prohibited conduct.

Prohibited conduct does not extend to reasonable actions of police officers acting to enforce the law or employees of the facility.
Definitions of terms

**ATSI health practitioner** means a person registered under the *Health Practitioner Regulation National Law* to practise in the Aboriginal and Torres Strait Islander health practice profession (other than as a student).

**Authorised**, in relation to an ATSI health practitioner, midwife, nurse or pharmacist, means authorised under the *Medicines, Poisons and Therapeutic Goods Act 2012 (NT)* to supply or administer a termination drug.

**Circumstances (medical)** relates to a term which may be used in statutory language that encompasses a person’s current and future physical, psychological, mental and social issues and/or condition.

**Credentialed** means having the verified qualifications, training, experience, professional standing and other relevant professional attributes of a medical practitioner used for the purpose of forming a view about the competence, performance and professional suitability of the medical practitioner.

**Facility** means an institution, place, building or agency that furnishes, conducts, and operates health services for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity, or physical condition.

**Fetus** means an unborn child.

**Health practitioner** means a person registered under one of the following health professions within the meaning of the *Health Practitioner Regulation National Law* (other than as a student): Aboriginal and Torres Strait Islander health practice; medical; nursing or midwifery; pharmacy.

**Midwife** means a person registered under the *Health Practitioner Regulation National Law* to practise in the nursing and midwifery profession as a midwife (other than as a student).

**MS-2Step** means the brand name for medications which are prescribed and dispensed as combined mifepristone and misoprostol for the purpose of terminating a pregnancy less than nine weeks.

**Nurse** means a person registered under the *Health Practitioner Regulation National Law* to practice in the nursing and midwifery profession as a nurse or as a midwife (other than as a student).

**Perform a termination** means the performance of any of the following actions, knowing that it is intended to induce an abortion:

- a. performs a surgical procedure; or
b. administers, supplies or procures the supply of any termination drug; or

c. any other means.

**Pharmacist** means a person registered under the *Health Practitioner Regulation National Law* to practise in the pharmacy profession (other than as a student).

**Premises for performing terminations** means premises where either or both of the following take place: terminations are performed by medical practitioners; and/or health practitioners assist in the performance of terminations.

**Professional standards and guidelines** means professional standards and guidelines applicable to medical practitioners in the performance of terminations, including standards and guidelines for the following matters: the assessment of a woman for a termination; the availability of suitable facilities and equipment for the performance of a termination; access to emergency services, if required, during or following a termination; procedures relating to the performance of a termination; and the availability of support services, including counselling.

**Publish** means communicate or disseminate information in a way or to an extent that makes it available to, or likely to come to the notice of, the public or a section of the public or anyone else.

**Safe access zone** means an area within a radius of 150 metres from the boundary of premises for termination services.

**Suitably qualified medical practitioner** is a medical practitioner who has the credentials set by the Chief Health Officer in the Northern Territory Clinical Guidelines for Termination of Pregnancy (these Guidelines).

**Termination** means intentionally inducing the abortion of a woman's pregnancy.

**Termination drug** means a substance or combination of substances, to which the current Poisons Standard applies under the *Therapeutic Goods Act 1989* (Cth), used for terminations.

**Woman** means a female person.
Bibliography


Gillick v West Norfolk and Wisbech Area Health Authority. (1985). 3 All ER 402 (HL).


Section 3: Appendices
Appendix A

Psychological support and counselling

**Information about psychological support and counselling**

Reproduced with permission from Queensland Maternity and Neonatal Clinical Guideline; *Therapeutic Termination of Pregnancy*, and RCOG Evidence-based Clinical Guideline Number 7 recommendations 6.2-6.6.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Recommended Practice Points</th>
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<tbody>
<tr>
<td>Pregnancy Options Information</td>
<td>Support the decision making process by providing accurate, impartial and easy to understand information including:</td>
</tr>
<tr>
<td></td>
<td>• options to continue the pregnancy and parent the child</td>
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<tr>
<td></td>
<td>• options to continue the pregnancy and place the child for foster care/adoption</td>
</tr>
<tr>
<td></td>
<td>• termination options, post-termination of pregnancy considerations including contraceptive options and counselling support</td>
</tr>
<tr>
<td></td>
<td>• suggested useful websites include Children by Choice (Queensland) <a href="http://www.childrenbychoice.org.au/">www.childrenbychoice.org.au</a></td>
</tr>
<tr>
<td></td>
<td>• Royal Women’s Hospital Victoria <a href="http://www.thewomens.org.au">www.thewomens.org.au</a>/health-information/unplanned-pregnancy-information.</td>
</tr>
<tr>
<td>The termination decision</td>
<td>• The ‘Pregnancy options for women in the Northern Territory’ booklet is to be provided.</td>
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<tr>
<td></td>
<td>• Suitably qualified medical practitioners must identify women requiring support in the decision making process.</td>
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<tr>
<td></td>
<td>• Pathways to additional support, including counselling and other support services, must be available but are not compulsory.</td>
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<tr>
<td></td>
<td>• Where a young woman is sixteen years of age or under, greater consideration of an independent and appropriate counsellor/support person being available and engaged is needed.</td>
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<tr>
<td></td>
<td>• Information about methods of termination of pregnancy and adverse effects must be provided.</td>
</tr>
<tr>
<td></td>
<td>• Where possible, women should be given the termination method of their choice and comprehensive explanations of why they may not be able to access their preferred method.</td>
</tr>
</tbody>
</table>
**Aspect** | **Recommended Practice Points**
--- | ---
Counselling | • Where required or requested, offer confidential, non-judgmental support and counselling pre and post termination.

• Counselling should be provided by a social worker, psychologist, or counsellor who:
  ▪ is appropriately qualified and/or trained
  ▪ is familiar with the issues surrounding termination of pregnancy and the woman’s circumstances and environment
  ▪ has no vested interest in the pregnancy outcome.

• Where feasible, offer counselling ‘close to home’ to aid the establishment of longer term counselling support. However this may also need to be over the telephone.

• Consider the requirement for formal mental health referral especially if there is a history of mental illness.

Mental health considerations | • There are limitations in the evidence examining the relationships between unwanted pregnancy, termination of pregnancy, birth and mental health.

• For the majority of mental health outcomes, there is no statistically significant association between pregnancy resolution and mental health problems.

• A woman’s mental health will be largely unaffected whether she has a termination or gives birth.

• Women with a past history of mental health problems may be at increased risk of further problems in the future.


## Appendix B

### Pre termination assessment and referral pathways

Pre termination assessment including pregnancy option information, counselling and psychosocial support services, should be offered ‘close to home’ where feasible.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Recommended Practice Points</th>
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</thead>
</table>
| Circumstances of pregnancy   | • Obtain a full picture of the circumstances leading to the request for termination of pregnancy.  
                                 • Offer referral to other services as appropriate, especially where risk factors are identified (e.g. young women, women with physical or intellectual disabilities, mental illness, rape or sexual assault, domestic violence, fertility issues and cultural beliefs/values). |
| Medical history               | • The ‘Pregnancy options for women in the Northern Territory’ booklet is to be provided  
                                 • Suitably qualified medical practitioners must identify women requiring support in the decision making process.  
                                 • Pathways to additional support, including counselling and other support services, must be available but are not compulsory.  
                                 • Where a young woman is sixteen years of age or under, greater consideration of an independent and appropriate counsellor/support person being available is needed.  
                                 • Information about methods of termination of pregnancy and adverse effects must be provided.  
                                 • Where possible women should be given the termination method of their choice, or comprehensive explanations of why they may not be able to access their preferred method. |
| Clinical exam and investigations | • Undertake a medical history and consider a woman’s need for interpreter services.  
                                 • Confirm the diagnosis of pregnancy by ultrasound, urinary or serum βhCG assay.  
                                 • Determine gestational age by ultrasound as this will impact on choice of termination method.  
                                 • Take cervico-vaginal swabs to allow treatment of bacterial infections prior to termination of pregnancy.  
                                 • Conduct routine antenatal screening including:  
                                  ▪ Haemoglobin level  
                                  ▪ blood group and Rh status to identify Rh negative women for administration of Anti-D. |

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<tr>
<th>Aspect</th>
<th>Recommended Practice Points</th>
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| Primary health care    | Consider primary health screening or advice, for example:  
• pap smear  
• sexual health check  
• Rubella titre  
• domestic and family violence or sexual violence, reproductive control and coercion screening with the woman ALONE  
• smoking cessation advice.                                                                                   |
| Referral coordination  | • Consider the requirement for a woman's timely referral and coordination with other facilities/disciplines/agencies particularly referring to the geographical location two hour rule for hospital treatment. Referrals may include:  
  • specialist medical assessment (e.g. cardiologist, clinical genetics services, tertiary imaging)  
  • psychosocial counselling/support  
  • mental health support/treatment.  
• Following the termination of pregnancy procedure, arrange a follow-up appointment in 14 to 21 days to facilitate assessment of physical recovery, confirmation of procedure success and discussion of ongoing contraception. |
| Contraception          | • Promote and facilitate commencement of contraception at the time of termination of pregnancy or immediately after  
  • Intrauterine devices may be inserted immediately post-termination if clinically appropriate  
  • Consider a long acting contraceptive such as etonogestrel implant (Implanon NXT) or tubal ligation that can be attended at the same time as a surgical termination or booked for after a medical termination. |


## Appendix C

### Early Medical Termination of Pregnancy: Recommended Practice Points

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<tr>
<th>Aspect</th>
<th>Recommended Practice Points</th>
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<tr>
<td><strong>General</strong></td>
<td>Early medical termination can be provided by a suitably qualified medical practitioner:</td>
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<td></td>
<td>• after a formal gestational age assessment by ultrasound</td>
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<td>• who has appropriate areas for privacy and confidentiality (N/A to Telehealth Services)</td>
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<td></td>
<td>• who offers a first (assessment) appointment within five days of referral</td>
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<td>• who provides termination of pregnancy as soon as possible</td>
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<td>• who makes available consumer and services information on the choices available within the</td>
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<td></td>
<td>service, and on routes of access to these services.</td>
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<td><strong>Protocols and assessment of</strong></td>
<td>The service provider must have formal protocols which guide staff to:</td>
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<tr>
<td><strong>risks</strong></td>
<td>• assess and manage the ‘normal risk’ woman, including the provision of information</td>
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<td>sufficient for her to provide informed consent</td>
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<td>• assess the woman’s access to safe accommodation, a reliable support person, a reliable</td>
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<td></td>
<td>telephone and reliable transport for the duration of the early medical termination</td>
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<td></td>
<td>• provide the credentials of the suitably qualified medical practitioner to any authorised</td>
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<td></td>
<td>pharmacist dispensing MS-2Step</td>
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<td>• educate the woman about remaining within two hours driving time of a hospital, including</td>
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<td></td>
<td>the development of an individualised care plan where required</td>
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<td></td>
<td>• facilitate an early referral of a woman to an obstetrician or gynaecologist (clinical</td>
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<td>complexities deemed ‘at risk’ and considering a termination of pregnancy)</td>
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<td></td>
<td>• assess and manage the woman requiring a termination of pregnancy greater than nine weeks’</td>
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<td></td>
<td>gestation</td>
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<td></td>
<td>• provide post termination support and follow up care information to the woman, her</td>
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<td>support person, and relevant health service providers, in accordance with the TGA</td>
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<td>certification risk management plan requirement</td>
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<td>• refer a women to emergency gynaecology services when transfer is required</td>
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<td></td>
<td>• consider using a written care plan for each woman to summarise this information.</td>
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<th>Aspect</th>
<th>Recommended Practice Points</th>
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</table>
| Workforce | Service providers have:  
• health practitioners who meet credentials as per these Guidelines with appropriate competencies relevant to providing termination of pregnancy services and maintain records of these credentials updated at least every two years  
• suitably qualified medical practitioner(s) in accordance with these guidelines and registered according to the TGA to prescribe MS-2Step  
• access to telehealth for the provision of part or all of the termination of pregnancy services. |
| Support services | The service provider has:  
• formal communication links with obstetrician and gynaecological services including ‘out of hours’ follow up care  
• established telecommunication links and formal protocols for contacting aerial retrieval services  
• formal protocols to guide staff wishing to transfer the woman requiring a level of care not available at the facility  
• formal protocols to guide staff in the development of the ‘post-termination procedure’  
• considered providing written information to the woman and her support person prior to discharge  
• assessed the woman’s access to safe accommodation post procedure  
• established referral pathways for the woman to easily access counselling services. |
| Pathology services | The service provider has access to local pathology services available for the hours the service is provided. |
| Pharmacy services relevant to the management of termination of pregnancy | The service provider has access to a pharmacist prepared to stock and supply MS-2Step for the suitably qualified medical practitioner(s) certified under the Therapeutic Goods Administration licensing conditions to prescribe MS-2Step. |


**Appendix D**

**Surgical Termination of Pregnancy up to 14 weeks’ gestation: Recommended Practice Points**

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Recommended Practice Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td>Service providers provide:</td>
</tr>
<tr>
<td></td>
<td>• a range of health care facilities and support services including on site operating room(s) and/or day surgery suite facilities. These rooms are maintained in accordance with relevant standards including:</td>
</tr>
<tr>
<td></td>
<td>• Australian College of Operating Room Nurses Standards</td>
</tr>
<tr>
<td></td>
<td>• Australian Day Surgery Nurses Association Guidelines</td>
</tr>
<tr>
<td></td>
<td>• Australian &amp; New Zealand College of Anaesthetists</td>
</tr>
<tr>
<td></td>
<td>• Recommendations for Perioperative Care of Patients Selected for Day Care Surgery</td>
</tr>
<tr>
<td></td>
<td>• National Safety and Quality Health Service Standards, Australian Commission on Safety and Quality in Health Care.</td>
</tr>
<tr>
<td><strong>Protocols</strong></td>
<td>The service provider must have formal protocols which guide staff to:</td>
</tr>
<tr>
<td></td>
<td>• assess and manage the ‘normal risk’ woman, including the provision of information sufficient for her to provide informed consent</td>
</tr>
<tr>
<td></td>
<td>• manage perioperative requirements</td>
</tr>
<tr>
<td></td>
<td>• facilitate the early referral to an obstetrician and gynaecologist of a woman with clinical complexities deemed ‘at risk’ and considering a termination of pregnancy</td>
</tr>
<tr>
<td></td>
<td>• assess and manage the woman requiring a termination of pregnancy more than 14 weeks’ gestation and refer to appropriate provider</td>
</tr>
<tr>
<td></td>
<td>• provide post procedural support and follow up care information to the woman and relevant health service providers, prior to discharge, in accordance with accreditation requirements</td>
</tr>
<tr>
<td></td>
<td>• manage a woman who requires emergency services</td>
</tr>
<tr>
<td></td>
<td>• refer a women to emergency gynaecology services when transfer is required.</td>
</tr>
<tr>
<td><strong>Service providers</strong></td>
<td>The service provider must have:</td>
</tr>
<tr>
<td></td>
<td>• appropriate areas for counselling that ensure the woman’s privacy and confidentiality</td>
</tr>
<tr>
<td></td>
<td>• emergency resuscitation equipment available as per accreditation requirements.</td>
</tr>
<tr>
<td>Aspect</td>
<td>Recommended Practice Points</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Workforce                                  | • The service provider has health practitioners who meet credentials as per these Guidelines with appropriate competencies relevant to providing termination of pregnancy services and maintain records of these credentials updated at least every two years.  
  • provides education programs to ensure maintenance of competencies.                                                                                                                                                     |
| Pathology services                         | Service providers have access to local pathology services which provide:  
  • examination of the products of conception by the surgeon which may assist with recognition of gestational trophoblast and exclude ectopic pregnancy  
  • histopathology if clinically indicated.                                                                                                                                                                                   |
| Blood and blood product/or volume expanders | Service providers maintain emergency transfusion supplies on site.                                                                                                                                                           |
| Pharmacy services relevant to the management of termination of pregnancy | Service providers have access to a pharmacy able to provide medications appropriate to the needs of the woman.                                                                                                                                 |
| Diagnostic medical imaging services        | Service providers have access to ultrasound services for pregnancies greater than 12 weeks gestation.                                                                                                                                 |
| Risk Assessment                            | Advise the woman that she must stay within a two hour drive from a hospital for 24 hours post procedure.                                                                                                                   |


Appendix E

Aftercare, complications and sequelae of termination of pregnancy: Recommended Practice Points

Women should be informed that termination of pregnancy is a low risk procedure and maternal mortality is rare for all gestations. Risks and complications should be discussed with the woman so that she is well informed. Successful completion of the Medical Termination of Pregnancy needs to be confirmed by a suitably qualified medical practitioner. Written information is to be provided to the woman about the symptoms she may experience and a list of those symptoms that would make an urgent medical consultation necessary.

<table>
<thead>
<tr>
<th>Aftercare</th>
<th>Recommended Practice Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal College of Obstetricians and Gynaecologists Evidence Based Clinical Guideline ‘The Care of Women Requesting Induced Abortion’</td>
<td>Chapter 8 ‘Care after Abortion’ is a suggested reference. <a href="http://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guidelines/abortion-guideline_web_1.pdf">www.rcog.org.uk/globalassets/documents/guidelines/abortion-guidelines/abortion-guideline_web_1.pdf</a></td>
</tr>
</tbody>
</table>
| General | General guidelines for a woman post termination are that:  
• she should seek medical care if she is concerned the termination is not complete  
• a hCG test (pregnancy test) may be needed to confirm completion of termination and if necessary an ultrasound may also be required but not routine  
• she should be aware of precautions needed to prevent possible infection post termination including refraining from intercourse for two weeks post termination; not using vaginal douches for two weeks; and avoiding heavy exercise or other activities that could increase risk of bleeding. |


April 2019 Version 2

NORTHERN TERRITORY DEPARTMENT OF HEALTH
### Complication Recommended Practice Points

<table>
<thead>
<tr>
<th>Complication</th>
<th>Recommended Practice Points</th>
</tr>
</thead>
</table>
| Physical symptoms                   | The most common physical symptoms experienced by women following termination of pregnancy include pain, bleeding and nausea and vomiting.  
Women should be advised of these physical symptoms and the situations that would lead to seeking medical advice.  
Women undergoing medical termination are more likely to experience more bleeding over the first two weeks than women undergoing surgical termination.  
Later gestations also experience a longer period of bleeding as the placental site is larger.  
The risk of severe bleeding requiring the need for blood transfusion is lower for early terminations, occurring in less than one in 1000, rising to approximately four in 1000 beyond gestations of 20 weeks.  
Vaginal bleeding usually commences one to two days after taking Mifepristone.  
The pregnancy may be expelled after a few hours of ingesting Misoprostol or in the course of the next few days.  
The bleeding lasts on average ten to 16 days and may be heavy. |
| Retained products of conception     | This outcome is uncommon following surgical termination.  
The requirement for surgical evacuation of retained products increases following medical termination.                                                                             |
| Infection                           | Infection risk reduced if:  
• prophylactic antibiotics are given  
• lower genital tract infection has been excluded by bacteriological screening.                                                                                                   |
| Cervical trauma                     | Cervical trauma rates vary. Risk of damage to the external cervix at the time of surgical termination is no greater than 1 in 100. This risk decreases with:  
• experienced clinician  
• use of preoperative cervical priming  
• earlier gestations.                                                                                                                                                      |
| Haemorrhage                         | The risk of haemorrhage may be more common following medical termination of pregnancy (bleeding may persist up to 45 days) but evidence is not conclusive:  
• Risk of haemorrhage:  
  • is lower at earlier gestations  
  • less than 13 weeks: 0.88 in 1000 terminations  
  • greater than 20 weeks: 4 in 1000 terminations.                                                                                                                        |
<table>
<thead>
<tr>
<th>Complication</th>
<th>Recommended Practice Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterine perforation</td>
<td>• The risk at the time of surgical termination is 1-4 in 1000&lt;br&gt;• Decreased risk of uterine perforation associated with:&lt;br&gt;  ▪ experienced clinician&lt;br&gt;  ▪ use of preoperative cervical priming&lt;br&gt;  ▪ earlier gestations.</td>
</tr>
<tr>
<td>Uterine rupture</td>
<td>• Uterine rupture has been rarely reported in association with mid-trimester medical terminations&lt;br&gt;• More frequently associated with later gestational ages and previous uterine scar less than 1 in 1000 terminations.</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>• Women should be informed that there is no evidence of termination of pregnancy being associated with a higher risk of breast cancer.</td>
</tr>
<tr>
<td>Maternal mortality</td>
<td>• The risk is estimated at 0.6 per 100,000 terminations&lt;br&gt;• First trimester procedures are safer than second trimester procedures&lt;br&gt;  ▪ 0.1-0.4 deaths per 100,000 first trimester procedures&lt;br&gt;  ▪ 1.7-8.9 deaths per 100,000 second trimester procedures&lt;br&gt;• Suction curettage has the lowest rate of any surgical pregnancy termination method.</td>
</tr>
<tr>
<td>Psychological sequelae</td>
<td>• Emotional responses following termination of pregnancy can be complex and may change over time.&lt;br&gt;• Risk factors for post-termination of pregnancy psychological problems may include: previous or concurrent psychiatric illness, coercion, length of gestation, ambivalence and lack of social support, poor relationships with others or religious affiliation.&lt;br&gt;• Adverse psychological sequelae are no more likely following termination than following continuation of the pregnancy.</td>
</tr>
<tr>
<td>Failure to achieve termination of the pregnancy</td>
<td>• Successful termination of pregnancy needs to be confirmed.&lt;br&gt;• All methods of first trimester termination of pregnancy carry a small risk of failure to terminate.&lt;br&gt;• Surgical method failure rates are approximately 2.3 in 1000&lt;br&gt;• Medical method failure rates increases with gestation&lt;br&gt;• More likely following early rather than late termination of pregnancy&lt;br&gt;• Failed termination of pregnancy while uncommon, may lead to fetal anomalies if the pregnancy persists.</td>
</tr>
<tr>
<td>Future pregnancies</td>
<td>• There are no proven associations between termination of pregnancy and subsequent ectopic pregnancy, placenta praevia or infertility issues.</td>
</tr>
</tbody>
</table>

## Appendix F  
Sample screening tool for domestic and family violence

### Prior to screening ensure the following is in place:
- Interview the client alone.
- Mandatory reporting obligations understood.
- Explain client participation is voluntary.
- Privacy and confidentiality limits discussed.

### Communication
- Interpreter required: [ ] Yes [ ] No
- Primary language spoken: ……………………………………………
- Preferred interpreter: [ ] Male [ ] Female
- Locally known interpreter: [ ] Yes [ ] No
- External unknown interpreter: [ ] Yes [ ] No

### Inform the client
**Before screening the client, in your own words explain:**

- [ ] General statement: Many people experience problems with their family, partner or someone they live with so we ask questions about the safety of all our clients.  
- [ ] If pregnant: Women who are pregnant commonly experience violence within the home, so we ask questions about the safety of all our clients.

Domestic and family violence is any type of abusive behaviour used to gain and maintain control over someone. Abuse does not have to be physical to be domestic and family violence.

It can take many forms e.g. controlling behaviours financial abuse (denying access to money), emotional abuse (name calling), intimidation (smashing things) isolation (preventing you from having contact with friends or family), sexual abuse (forcing you to have sex, touching you without your permission) or spiritual abuse (putting down your culture or your beliefs).

- Explain that participation is voluntary and this document will be placed on their medical file.

### Screening questions - explain that you will ask them five questions, which will require a yes / no answer.

1. Within the last year has your partner ex-partner or family yelled at you, talked down to you or called you bad names?  
2. Within the last year has your partner or anyone in your family become jealous or tried to control what you do?  
3. Within the last year, have you been afraid of your partner, ex-partner or anyone in your family?  
4. Within the last year, have you been hit, kicked, punched or hurt by your partner or anyone in your family?  
5. Within the last year, have you been made to have sex or have any sexual activity when you didn’t want to by your partner, ex-partner or someone in your family?  

If the client answered "yes" to any of the above questions, offer the person a supportive response. Provide an opportunity to tell their story. For example, ask "Would you like to talk more about this?" or ask "how can we help?"

### Next steps

- **Result**
  - No screening because:
    - [ ] Client declined to answer
    - [ ] Partner present
    - [ ] Family / friends present
    - [ ] Interpreter not available
  - [ ] D&FV disclosed - continue with the Domestic and Family Violence Assessment Form
  - [ ] D&FV suspected - continue with the Domestic and Family Violence Assessment Form
  - [ ] D&FV not disclosed - file this record in the client’s medical record.

- Save record on client’s medical file.

### Form Completed by (print name)  
Designation  
Signature  
Date
# Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIS</td>
<td>Aboriginal Interpreter Service</td>
</tr>
<tr>
<td>APP</td>
<td>Advanced Personal Plan</td>
</tr>
<tr>
<td>ARTG</td>
<td>Australian Register of Therapeutic Goods</td>
</tr>
<tr>
<td>ASH</td>
<td>Alice Springs Hospital</td>
</tr>
<tr>
<td>βhCG</td>
<td>Beta human chorionic gonadotropin</td>
</tr>
<tr>
<td>BP</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>FBE</td>
<td>Full Blood Examination</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>Gyn</td>
<td>Gynaecology</td>
</tr>
<tr>
<td>HS</td>
<td>Health Services</td>
</tr>
<tr>
<td>ITSNT</td>
<td>Interpreting and Translating Service Northern Territory</td>
</tr>
<tr>
<td>IUC</td>
<td>Intrauterine Contraceptive</td>
</tr>
<tr>
<td>LAM</td>
<td>List of Approved Medicines</td>
</tr>
<tr>
<td>MS-2Step</td>
<td>Medication used in an early medical termination of pregnancy</td>
</tr>
<tr>
<td>NT</td>
<td>Northern Territory</td>
</tr>
<tr>
<td>NTCAT</td>
<td>Northern Territory Civil Administrative Tribunal</td>
</tr>
<tr>
<td>PATS</td>
<td>Patient Assistance Travel Scheme</td>
</tr>
<tr>
<td>RANZCOG</td>
<td>Royal Australian and New Zealand College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>RDH</td>
<td>Royal Darwin Hospital</td>
</tr>
<tr>
<td>Rh</td>
<td>Rhesus</td>
</tr>
<tr>
<td>SQMP</td>
<td>Suitably Qualified Medical Practitioner</td>
</tr>
<tr>
<td>STI</td>
<td>Sexual Transmitted Infections</td>
</tr>
<tr>
<td>TGA</td>
<td>Therapeutic Goods Administration</td>
</tr>
<tr>
<td>the Act</td>
<td>Terminations of Pregnancy Law Reform Act 2017</td>
</tr>
<tr>
<td>the Regulations</td>
<td>Terminations of Pregnancy Law Reform Regulations</td>
</tr>
<tr>
<td>TISN</td>
<td>Translating and Interpreting Service National</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of Pregnancy</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
</tbody>
</table>
Clinical Guidelines for Termination of Pregnancy

Northern Territory Department of Health
www.health.nt.gov.au